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DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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TO: The Honorable Toni Nathaniel Harp, Senate Chair
The Honorable John Geragosian, House Chair
The Honorable Dan Debicella, Senate Ranking Member
The Honorable Craig Miner, House Ranking Member
Members of the Appropriations Committee

The Honorable Paul Doyle, Senate Chair
The Honorable Toni Walker, House Chair
The Honorable Robert Kane, Senate Ranking Member
The Honorable Lile R. Gibbons, House Ranking Member
Members of the Human Services Committee

FROM: Michael P. Starkowski
Commissioner

RE: **PROPOSED 1915(b) MEDICAID MANAGED CARE WAIVER (HUSKY A)**

DATE: March 2, 2009

In accordance with the provisions of Section 17b-8 of the Connecticut General Statutes, I am pleased to submit to the Human Services and Appropriations Committees of the Connecticut General Assembly a proposed federal Medicaid Managed Care Waiver to govern Connecticut's HUSKY A program. The current waiver period ends June 30, 2009 and the department anticipates submitting the new Medicaid Managed Care (HUSKY A) waiver application to the federal government as authorized under section 1915(b) of the Social Security Act for the period of 7/1/2009 through 6/30/2011. HUSKY A provides comprehensive health care coverage to low-income children and adults through mandatory managed care. The HUSKY A population includes children up to age 19 and their parents or relative caregivers up to 185% of the federal poverty level, children up to age 21 and their parents in poverty-level related groups, pregnant women up to 250% of the federal poverty level and children in the care of the Connecticut Department of Children and Families.

The Medicaid managed care program was first implemented in 1995 and currently serves approximately 222,000 children and over 107,000 adults. Please note that although the program has been operating under 1915 (b) waiver authority since its inception in 1995, due to major changes in the program, such as the transition of behavioral health and dental services from the managed care contracts to non-risk administrative services arrangements, the application to CMS is for new waiver approval rather than a waiver renewal.

This waiver is designed to provide cost-effective access to quality health care services, effective outreach and client education, coordination and management of care.

We welcome the opportunity to meet with you at your earliest convenience to discuss our ongoing vision and commitment to the HUSKY a population. Please do not hesitate to contact our agency legislative liaison, Matthew Barrett (424-5012), for the purpose of scheduling a meeting or should you have any questions or concerns in the meantime.

Thank you.

cc: The Honorable M. Jodi Rell, Governor
The Honorable Robert Genuario, Secretary, OPM

Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs

MMA Amendment Version
July 18, 2005
Draft

Table of Contents

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet
Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of Connecticut requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is HUSKY A (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

X initial request for new waiver. All sections are filled.

___ amendment request for existing waiver, which modifies Section/Part ____

__ Replacement pages are attached for specific Section/Part being amended (note:
the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

__ Document is replaced in full, with changes highlighted

renewal request

This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

__ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is
- ___ replaced in full
- ___ carried over from previous waiver period. The State:
  - ___ assures there are no changes in the Program Description from the previous waiver period.
  - ___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is
- ___ replaced in full
- ___ carried over from previous waiver period. The State:
  - ___ assures there are no changes in the Monitoring Plan from the previous waiver period.
  - ___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective July 1, 2009 and ending June 30. 2011 (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Rose Ciarcia and can be reached by telephone at (860) 424-5139, or fax at (860) 424-4958, or e-mail at Rose.Ciarcia@ct.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Response

The Department periodically meets with leaders and health officials from the Mashantucket Pequot tribal nation and the Mohegan tribal nation to review program changes, provide program information and to respond to any questions they may have. The Department most recently met with the Mohegan tribe during July 2008 to provide updates on program changes, brief them about the upcoming waiver renewal and to address their questions and comments. A similar meeting with the Mashantucket Pequot tribe has been rescheduled at their request due to staffing turnover. They have asked that the Department wait to reschedule the meeting until after they have their new health center director in place.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. X **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- X MCO
- ___ PIHP
- ___ PAHP
- X PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- ___ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a._X__ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

MCOs are available statewide, however since Primary Care Case Management (PCCM) is initially being implemented as a pilot, it is not available statewide and is being limited to certain HUSKY A beneficiaries. To qualify for enrollment in PCCM, at least one family member must be a patient of a PCCM participating provider.

b. X **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c. X **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

d.___ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. Delivery Systems. The State will be using the following systems to deliver services:

a. **X** **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

Response

The MCO risk-comprehensive contracts cover all services except behavioral health; dental and pharmacy services, which are reimbursed under fee-for-services. For behavioral health and dental services, the Department has contracted with administrative services organizations to manage and coordinate the services for all HUSKY A clients, whether enrolled in PCCM or with an MCO. The Medicaid FFS network of behavioral health and dental providers are used for the delivery of behavioral health and dental services. Likewise, HUSKY A clients access pharmacy services from Medicaid enrolled pharmacies.

b. **PIHP:** Prepaid Inpatient Health Plan means an entity that:

(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

___ The PIHP is paid on a risk basis.
The PIHP is paid on a non-risk basis.

c.___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.

___ The PAHP is paid on a non-risk basis.

d. X **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e.___**Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f.___ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

X **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
___ **Open** cooperative procurement process (in which any qualifying contractor may participate)
___ **Sole source** procurement
X **Other** (please describe) Application process for PCCM

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **Assurances.**

X The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

___ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

X Two or more MCOs
X Two or more primary care providers within one PCCM system.
The department has initially implemented a pilot PCCM program in select areas of the state with select providers.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
___ Other: (please describe)

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

___ Beneficiaries will be limited to a single provider in their service area (please define service area).
___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

X **Statewide** -- all counties, zip codes, or regions of the State

Response
(The PCCM program will be initiated as a pilot with providers in Waterbury and Windham/Mansfield areas. At a later date the program will be rolled out in other areas in which there are sufficient providers to allow options for both adults and children in HUSKY A-eligible households).

___ **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Fairfield	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT
Hartford	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT
Litchfield	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT
Middlesex	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT
New Haven	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT
New London	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT
Tolland	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT
Windham	MCO (PCCM potential)	AETNA, AmeriChoice, CHNCT

Statewide	Administrative Services Organization (ASO)	Value Options – Behavioral Health and Substance Abuse Services
Statewide	Administrative Services Organization (ASO)	BeneCare – Dental Services

PCCM:
In September 2008, the Department released a Request for Application to enroll providers who will offer Primary Care Case Management services. The RFA was issued for a statewide solicitation. The pilot began effective 2/1/2009 with providers in Waterbury (New Haven County) and Mansfield and Windham area (Windham County). Current patients of these providers, regardless of the particular town or county in which they live, are eligible to enroll in PCCM.

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

X **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

X Mandatory enrollment
___ Voluntary enrollment

X **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

X Mandatory enrollment
___ Voluntary enrollment

___ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

___ Mandatory enrollment
___ Voluntary enrollment

___**Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

_X_ Mandatory enrollment
___ Voluntary enrollment

___ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

___ Mandatory enrollment
___ Voluntary enrollment

X **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

X Mandatory enrollment
___ Voluntary enrollment

___ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

___ Mandatory enrollment
___ Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

X **Medicare Dual Eligible**--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

___ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

___ **Other Insurance**--Medicaid beneficiaries who have other health insurance.

X **Reside in Nursing Facility or ICF/MR**--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

___ **Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

___ **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

X **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

_____ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

X **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

___ **Other** (Please define):

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

X ***The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.***

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.

- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

___ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

X The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

___The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

___The State will pay for all family planning services, whether provided by network or out-of-network providers.

X Other (please explain): The State will pay for family planning services for PCCM enrolled individuals.

___Family planning services are not included under the waiver.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

X The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to

FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

Response:

In addition to one of the participating MCOs being FQHC-based, FQHCs are available in all three plans. Effective no later than September 1, 2009 FQHCs will bill and be reimbursed by the State's fiscal intermediary, EDS. The FQHCs will continue to have a contractual relationship with the MCOs for the purposes of care coordination, quality assurance, performance improvement initiatives and coordination of EPSDT services.

___The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

X The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

___This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

X The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

a. Emergency Services

b. Family Planning

c. Female enrollees have direct access to women's health specialist within the network for covered care related to women's routine and preventive care.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

~~A.~~A. Timely Access Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

Response

The Connecticut legislature in the June 2007 special session directed the Commissioner of Social Services to develop and implement a pilot program for alternative approaches in the delivery of health care services through a system of primary care case management to not less than one thousand individuals who are otherwise eligible to receive HUSKY Plan, Part A (Medicaid managed care) benefits. Initially, the program is being piloted and limited to select primary care providers and their current enrollees who select PCCM. Based on efficacy and other factors the Department will evaluate the expansion of the program to individuals residing in other areas of the state.

Primary Care Case Management (PCCM) is a system to manage and coordinate care by a primary care provider (PCP), instead of a managed care organization. The PCP is

responsible for approving and monitoring the care of enrolled Medicaid beneficiaries, for a monthly case management fee in addition to fee-for-service reimbursement for medical services and treatment. This case management fee pays for such things as locating, coordinating, and monitoring the health care services received by their patients.

Participating PCCM providers and practices will receive a case management fee to hire case managers, to provide the resources and support needed for physician practices to better manage the care of enrollees. Case managers may serve as patient advocates, and intervene with other community based health and social service organizations to assure the patient receives all necessary and coordinated services.

PCCM case management brings PCPs, hospitals, health departments, and other community providers together to manage the health care needs of Medicaid recipients. Each selected PCP or group practice will identify and designate a case manager who will assist the development, implementation, and evaluation of the case management strategies.

a. X **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. X PCPs (please describe):
2. ___Specialists (please describe):
3. ___Ancillary providers (please describe):
4. ___Dental (please describe):
5. ___Hospitals (please describe):
6. ___Mental Health (please describe):
7. ___Pharmacies (please describe):
8. ___Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

Response

The Department's Primary Care Case Management Program shall conform to the Department's Medicaid Fee-For-Service program standards. The pilot program will be restricted to select Medicaid enrolled primary care providers and their current patients. PCCM enrolled beneficiaries will have access to the panel of providers enrolled in the State's Medicaid program. The program anticipates the same availability for PCCM patients that the Medicaid enrolled providers make available to their other patients.

b. X **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. __X_ PCPs (please describe): In provider agreements, PCCM PCPs agree to:
   a. Provide or arrange for primary care coverage for "on-call" services, consultation or referral, and treatment for urgent medical conditions, twenty-four (24) hours per day, seven (7) days per week, with a mechanism of support to be determined by the Department. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
   b. Provide care for or schedule an appointment with the Member within 6 weeks of calling for an appointment for a well-care visit, within 10 days of calling for an appointment for a non-urgent, symptomatic visit and within 48 hours for an Urgent Visit.
2. __X_Specialists (please describe): see response below
3. __X Ancillary providers (please describe): see response below
4. __X_Dental (please describe): see response below
5. __X_Mental Health (please describe): see response below
6. __X Substance Abuse Treatment Providers (please describe): see response below
7. __X_Urgent care (please describe): within 48 hours
8. ___ Other providers (please describe):

Specialists and ancillary providers are required to provide the same availability for PCCM patients that they make available to their other patients.

Dental: - Routine care (prevention included) or emergent care visits must be scheduled within eight (8) weeks. Urgent dental cases are referred and seen within forty-eight (48) hours of Primary Care Dental Provider notification.

Mental Health/ Substance Abuse
The Connecticut Behavioral Health Partnership (CT BHP) has no general appointment scheduling requirements; however, the CT BHP does have appointment scheduling requirements for any mental health or substance abuse clinic that has applied for and received designation as an Enhanced Care Clinic (ECC). These appointment scheduling requirements include the following:

- Clients who present at the designated ECC with an emergent condition must be evaluated by a clinician within two (2) hours of presenting to the ECC, whether or not the client has undergone a telephonic pre-screening.
- Clients that undergo telephonic or walk-in screening and are determined by the ECC to be urgent must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days (including weekends) of the screening.
- Clients that undergo telephonic or walk-in screening and are determined by the ECC to be routine must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within 14 calendar days of the screening.
- Following an initial face-to-face clinical evaluation, those clients who are determined to be clinically appropriate to receive outpatient services must be offered a follow-up appointment within 14 calendar days of the initial evaluation. For clients that require a more intensive service than outpatient, the clinic must facilitate linkage to the more appropriate service. If timely linkage is not possible, the clinic must provide follow-up care to the client until such linkage is possible and such follow-up care shall be subject to the 14-day requirement. This 14-day requirement applies to follow-up for a medication evaluation when indicated as well as nonmedical treatment services.

c. **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

~~B.~~B. Capacity Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

X The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. X The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

Response:
In the pilot PCCM program, each of the PCPs indicate in their respective contracts how many members they are willing to see. The maximum that a provider can agree to is 1,200 members. However, the Department will, for PCPs with a HUSKY A panel of 1,200 or more members (across all MCOs *and* PCCM), monitor members' access to care and can close the provider's HUSKY A panel if necessary – or allow more than 1,200 members if patient access can be assured.

b.___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

c.___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide

average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*
Willimantic/Mansfield	1:1200 (across MCOs and PCCM)
Waterbury	1:1200 (across MCOs and PCCM)
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

~~C.~~Coordination and Continuity of Care Standards

1. **Assurances For MCO, PIHP, or PAHP programs.**

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs.**

The following items are required.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. X **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

Response:

The enrollment files provided by the state to the MCOs include information used by the MCOs to identify individuals with special health care needs. Based on the Medicaid coverage group contained in the files, the MCOs can identify foster children; subsidized adoption children and children in the care of the Department of Children and Families. The files also include an indicator to identify individuals receiving SSI. Title V children will be identified via a file transfer from the Department of Public Health to the CT-DSS. DSS will share Title V information with the MCOs.

c. X **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

Response

The Department requires each MCO to implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the state to identify any ongoing special conditions that require a course of treatment or regular care monitoring as stated in the following provisions. See contract sections 3.04 and 4.02 copied below.

3.04 Coordination and Continuation of Care

The MCO shall implement and maintain, at a minimum, the following patient care management processes to assure that Members receive appropriate patient care according to relevant professional standards and DEPARTMENT requirements

a. Management and integration of health care through a PCP, gatekeeper or other means.
b. Referral process for medically necessary specialty, secondary and tertiary care.
c. Emergency care process, including Member education and instruction regarding where and how to obtain medically necessary care in emergency situations.
d. A process by which Members may obtain a contract service that the MCO does not provide or for which the MCO does not arrange because it would violate a religious or moral teaching of the religious institution or organization with which the MCO is owned, controlled, sponsored or affiliated.
e. Coordination and provision of EPSDT/well-child screening services in accordance with the schedules for immunizations and periodicity of well-child services as established by the DEPARTMENT and federal regulations.
f. EPSDT/well-child case management services through PCPs for HUSKY A and HUSKY B Members under twenty-one (21) years of age when the Member has a physical or mental health condition that makes the coordination of medical, social, and educational services medically necessary. As necessary, case management services shall include but not be limited to:
    1. Assessment of the need for case management and development of a plan for services;
    2. Periodic reassessment of the need for case management and review of the plan for services;
    3. Referring for related medical, social, and educational services;
    4. Facilitating referrals by providing assistance in scheduling appointments for health and health-related services, and arranging non-emergency medical transportation (for HUSKY A Members only) and interpreter services;
    5. Coordinating and integrating the plan of services through direct or collateral contacts with the family and those agencies and providers providing services to the child;
    6. Monitoring the quality and quantity of services being provided;
    7. Providing health education as needed; and
    8. Advocating to minimize conflict between service providers and to mobilize resources to obtain needed services.
g. Coordination and case management services for HUSKY A and HUSKY B Members who are children with special health care needs.

h. Inclusion and participation of PCPs, when requested, in the review and authorization of Individual Education Plans for HUSKY A and HUSKY B Members receiving School Based Child Health services and Individual Family Service Plans for HUSKY A and HUSKY B Members receiving services from the Birth to Three program.
i. Coordination of Members' care with the CT BHP ASO, as outlined in this contract, including but not limited to section 3.17, Mental health and Substance Abuse Access.

4.02 Persons with Special Health Care Needs

a. The DEPARTMENT will provide to the MCO information that identifies HUSKY A Members who are:
   1. Eligible for Supplemental Security Income;
   2. Over sixty-five (65) years of age;
   3. Children receiving foster care or otherwise in an out-of-home placement or receiving Title IV E foster care or adoption services; and
   4. Children enrolled in Title V's Children with Special Health Care Needs program.
b. The MCO shall conduct an assessment of these individuals and HUSKY A Members with special health care needs and make a referral to the Member's PCP to develop a treatment plan, as appropriate.
c. The MCO shall have a mechanism in place to allow HUSKY A Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

d. X **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

   1. X Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

   2. X Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

   3. X In accord with any applicable State quality assurance and utilization review standards.

e. ___ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs. See contract sections 3.13, 4.01 and 4.02 copied below.

Response

3.13 Second Opinions, Specialist Providers and the Referral Process

The MCO shall:

a. Provide for a second opinion from a qualified health care professional within its provider network, or arrange for the Member to obtain one outside the network, at no cost to the Member.

b. Contract with a sufficient number and mix of specialists so that the anticipated specialty care needs of Members can be substantially met within network providers.
c. Refer Members to out-of-network specialists when appropriate network specialists are not available.
d. Make specialist referrals available to its Members when it is medically necessary and medically appropriate.
e. Assume all financial responsibility for all in-network or out-of-network referrals and ensure that, except for applicable cost-sharing requirements (see Section xxx), the Member shall not incur any costs for such referrals.
f. Implement and maintain policies and procedures for the coordination of care and the arrangement and documentation of all referrals to specialty providers.

4.01 Specialized Outpatient Services for Children under DCF Care and Out-of-State Residential Treatment – (HUSKY A)

a. The MCO shall pay for a comprehensive multi-disciplinary examination for initial placement only, for each HUSKY A Member under the age of twenty-one (21) entering the care of the Department of Children and Families (DCF), within thirty (30) days of placement into out-of-home care.

    1. The multi-disciplinary examination shall consist of a thorough assessment of the Member's functional, medical, developmental, educational, and mental health status.

    2. The evaluation shall identify any additional specialized diagnostic and therapeutic needs within each area of the assessment.

    3. Physicians and other medical and mental health providers specializing in the assessment areas shall conduct the multi-disciplinary examination.

    4. Each multi-disciplinary examination shall occur at a single location.

    5. All components of the examination shall be performed on the same day, excluding additional needed examinations, unless otherwise indicated.

    6. The multi-disciplinary examination provider shall report the findings and conclusions of the examination in a form acceptable to DCF. The report must be received by DCF within fifteen (15) days of the examination. The provider shall also provide updates to DCF on any additional examinations.

b. The MCO's providers shall provide foster parent training on the use of special equipment or medications as needed.

c. The MCO shall require regular collaboration between providers and DCF Regional Offices and Central Office medical, mental health and social work staff and consultants. The MCO shall assign staff to act as liaisons to identify, address and resolve health care delivery issues, barriers to comprehensive care and other problem areas. DCF shall specify the contact persons by name, title and phone number who will be available for periodic meetings between DCF and the MCO and shall facilitate the initiation of these meetings with the MCO.

d. When DCF places a child in an out-of-state residential treatment facility, either at initial enrollment or during an enrollment period with the MCO, the MCO shall be financially responsible for services not covered in the per diem rate of the facility.

4.02 Persons with Special Health Care Needs

a. The DEPARTMENT will provide to the MCO information that identifies HUSKY A Members who are:
   1. Eligible for Supplemental Security Income;
   2. Over sixty-five (65) years of age;
   3. Children receiving foster care or otherwise in an out-of-home placement or receiving Title IV E foster care or adoption services; and
   4. Children enrolled in Title V's Children with Special Health Care Needs program.

b. The MCO shall conduct an assessment of these individuals and HUSKY A Members with special health care needs and make a referral to the Member's PCP to develop a treatment plan, as appropriate.

c. The MCO shall have a mechanism in place to allow HUSKY A Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. X Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. X Each enrollee is receives **health education/promotion** information. Please explain.

As part of the PCCM PCP provider agreement, PCPs agree to provide patient education designed to assist Members in managing their own care and appropriately using their medical equipment and pharmaceutical products.

d. X Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. X There is appropriate and confidential **exchange of information** among providers.

f. X Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. X Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. X **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

Response:
Case managers are responsible for follow-up to ensure that referred providers feed back information to the PCP and the case manager. The case manager is responbsible for updating the medical record.

i. X **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Response:
The PCCM Provider Advisory Group will advise the Department on uniform processes and forms to be used by PCCM PCPs.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs.**

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on 2/13/09.

X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Mercer Government Human Services Consulting (Mercer)	Annual Review	mandatory activities (reference 42 CFR § 438.358):	
PIHP				

2. **Assurances For PAHP program.**

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. _X_ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1._X__Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3._X__ Request PCCM's response to identified problems;

4._X__ Refer to program staff for further investigation;

5._X__ Send warning letters to PCCMs;

6._X__ Refer to State's medical staff for investigation;

7._X__ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10._X__ Further limit the number of assignments;

11. _X__ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13._X__ Suspend or terminate PCCM agreement;

14._X__ Suspend or terminate as Medicaid providers; and

15._X__ Other (explain): If the PCP has not complied with the terms of the provider agreement, the Department also can withhold all or part of the Provider's monthly PCCM management/coordination fee; refer the Provider to the Department's Fraud Unit or to the State Attorney General; refer the Provider to the Connecticut Medical Examining Board; and/or recover payment for case management services not rendered.

c. _X__**Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. _X_ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. __ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. _ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.

      ___ The complaint and appeals system.

      ___ Enrollee surveys.

      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. _X_ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. X Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ___ Other (please describe).

d. ___ **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

~~A.~~Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

X The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**

a. **Scope of Marketing**

1.___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2._X__ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

Response:
Plan brochures, posters, mobile billboards, radio and television and print advertisements, displays at public events that may include health education and promotion materials featuring general health improvement or prevention activities. For PCCM, PCCMs may also display approved materials in their offices.

3. X The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted

Response

Direct marketing is allowed only in public meetings, such as health fairs, and only using pre-approved materials such as brochures and token items. CT does not allow unsolicited mail to prospective members.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1 X The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/ selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

Response

The State prohibits the MCOs and providers from offering gifts to potential members with the exception of "give-aways" of nominal value when those items are approved by the Department prior to their distribution. This activity is monitored by relying on complaints or statements made by the members to the enrollment broker when a member requests transfer to a different MCO or PCCM.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

Response:

DSS requires all marketing materials to be published in both English and Spanish. Also, if more than 5% of members of an MCO speak another language the MCO is required to publish marketing materials in those languages. At this time no other language has been identified with at least 5% of an MCO's membership. DSS reviews all marketing and member targeted materials for compliance with contract and marketing guidelines including the language requirement. PCCMs are required to make written information available in prevalent non-English languages.

The State has chosen these languages because (check any that apply):

i. X The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

Response:
The Department through its eligibility management system (EMS), tracks languages spoken in a member's household. The data indicate a Spanish language indicator for 11% of all HUSKY A households.

ii. X The languages comprise all languages in the service area spoken by approximately 5% percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

X The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.**

a. **Non-English Languages**

X Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

Response:

The Department requires each MCO to produce member educational materials in English and Spanish and any other written language when more than five percent of a particular MCO's members in any county speak that language. PCCMs are required to make written information available in prevalent non-English languages.

The State defines prevalent non-English languages as: (check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. X The languages spoken by approximately 5 percent or more of the potential enrollee/ enrollee population.

3.__ Other (please explain):

X Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

Response:

For MCOs: See contract section 3.26 copied below.

3.26 Linguistic Access

a. The MCO shall take appropriate measures to ensure adequate access to services by Members with limited English proficiency. These measures shall include, but not be limited to:

   1. Promulgation and implementation of linguistic accessibility policies with application for MCO staff, network providers and subcontractors;
   2. Identification of a single individual at the MCO for ensuring compliance with linguistic accessibility policies;
   3. An assertive effort to identify individuals with linguistic access needs and persons with limited English proficiency as soon as possible following enrollment;
   4. Provision of both oral interpretation and materials translation services;
   5. Provision of a Member Handbook, notices of action and grievance/administrative hearing information in languages other than English, and
   6. Notification to its members that oral interpretation is available for any language.

b. The MCO shall provide Member educational materials in languages other than English and Spanish if more than five percent (5%) of the MCO's Members in the State of Connecticut speak the alternative language. However, this requirement shall not apply if the alternative language has no written form. Additionally, the materials shall take into consideration the special needs of those who, for example, have limited reading proficiency. The MCO may rely upon initial enrollment and monthly enrollment data from the DEPARTMENT to determine the percentage of Members who speak alternative languages. In all materials and correspondence, the MCO shall inform members that written materials are available in these alternative languages.

For PCCM:

PCCMs must: "Comply with all applicable laws, regulations, and policies regarding language access for Members, including making written information available in the prevalent non-English languages the Provider's particular service area and by making oral interpretation services available in all non-English languages free of charge to each Member. Provider must also notify Members about the availability of said written information and oral interpretation services."

For materials distributed by the Department, the Department must: "Provide written materials to Members and potential Members in a manner that is easily understood, in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency."

X The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

Response

Medicaid eligible individuals receive information regarding managed care, available MCO options, procedures to enroll and comparative information from several sources. The Department, ACS (the Department's single point of entry and enrollment broker), Infoline and outreach contractors provide comprehensive approach to reaching out to Medicaid eligible individuals. "Covering Kids and Families" developed materials and made the available to outreach contractors and other stakeholders and other programs and organizations serving the same population.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

X State

X contractor (please specify) _____

The Department contracts with the following entities to conduct outreach

Wheeler Clinic - Northern Region - Serving New Britain Area

Bridgeport SBHC - Western Region - Serving Bridgeport area

CRT - Northern Region - Serving Hartford Area

New Life Corp - Southern Region - Serving the Greater New Haven Area

Optimus Health Care - Western Region - Serving Stamford Area

Statewide and Regional Contractors

Allied Community Resource
Statewide and Regional - Serving the Northern Region

CAFCA Southern & Western Region

Regional Educational Service Centers (RESCS)

ACES of Hamden
outreach for Five Priority School Districts)
East Hartford, New Britain, Meriden, Norwalk, Norwich

Priority School District

Hartford - Northern - Hartford Schools

New Haven - Southern Region

Waterbury - Western Region

Ansonia - Southern Region

Bristol - Northern Region

Danbury - Western Region

New London - Southern Region

Stamford - Western Region

Bridgeport - Western Region

Windham - Northern Region

___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

Response:

Connecticut's public outreach and education initiative has evolved from multi-level campaigns and contracted outreach programs toward more targeted and specific activities. The Department's outreach contractors, including the States priority school districts and the Department's target uninsured children and provide their families with HUSKY application as well and managed care information. Additionally the Department's contracted enrollment broker as well as HUSKY Infoline provide information telephonically to interested callers.

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) X The State
The State provides enrollment confirmation and general information on how to access care

(ii) X State contractor (please specify):_____
Outreach contractors

(ii) X the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider
The MCOs provide a "welcome letter", a member handbook, newsletters and other informational materials.

C. Enrollment and Disenrollment

1. **Assurances.**

X The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. X **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Response:

The Department's outreach program includes:

- Customer service through a toll-free hotline;
- Written materials and updates;
- Web-based information and email customer response (www.huskyhealth.com);
- School-based linkage (i.e., free- and reduced-price school lunch program in cooperation with the CT Department of Education and school food service directors.
- Support for the work of local health and human services partners with information, advocacy and updated materials; and similar activities.

b. **Administration of Enrollment Process.**

___ State staff conducts the enrollment process.

X The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Response:

Broker name: ACS State Healthcare, LLC.

In a letter to CMS dated September 22, 2009, the Department provided information requested by CMS regarding business affiliations of ACS State Healthcare, LLC which might impact their independence and freedom from conflict of interest status. The Department is awaiting further direction from CMS.

Please list the functions that the contractor will perform:

X choice counseling

X enrollment

X_ other (please describe): Point of entry for HUSKY applications. Screening and Referral of potentially eligible HUSKY A applications. Passive Billing – calculation of capitation payment to MCOs.

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

X If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. X Potential enrollees will have 30 days/month(s) to choose a plan.

ii. X Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

Response: See contract section 7.03 copied below

7.03 Default Enrollment

a. The DEPARTMENT will assign to the MCO those Members who do not select a managed care plan within the period available for them to select a managed care plan. The DEPARTMENT will assign the Members on a rotating basis among all of the participating managed care plans and as each managed care plan's enrollment capacity allows.

b. The default assignment methodology is structured to evenly distribute families among all the participating managed care plans. However, due to variability in a managed care plan's enrollment capacity, family size and loss of eligibility, the outcome of the default assignment may not result in an even net default distribution

Upon Medicaid grant, families receive written materials and MCO comparison information by mail. Enrollment counseling staff is available by telephone through a toll-free number. The enrollment broker reaches out to new Medicaid families to assist them in choosing a plan. A beneficiary has thirty days in which to select a health plan after he/she has been notified that he/she is eligible. Information is also available on site at the Department's field offices and community organizations and programs.

Newly eligible Connecticut Medicaid beneficiaries who are mandated for enrollment into managed care are notified by mail of the requirement to enroll in an MCO. The notification includes plan information; instructions on how to enroll; an enrollment form and information on the consequences of not making a selection.

The enrollment broker performs the functions of single point of entry for all HUSKY (A and B) applications, screens applications for HUSKY A eligibility, refers potential HUSKY A applications to the appropriate DSS Regional Office, determines eligibility for HUSKY B (SCHIP); enrolls individuals in a managed care organization; and assists enrollees with the initial selection of primary care providers for each eligible individual in the family. In addition the broker maintains sufficient data management capacity to manage such decisions and integrate data applications with the CT-DSS systems.

The Department requires the broker to employ selection counselors with appropriate skills to counsel families and assist with plan and PCP selection. CT-DSS monitors the performance of the selection counselors by reviewing the case notes on a monthly basis and following up on complaints as necessary.

The Department requires the MCOs to conduct continuous open enrollment during which the MCO must accept clients eligible for coverage in the order in which they are enrolled without regard to health status of the client. There is no enrollment lock-in period.

Please note that members are not defaulted into PCCM.

___ The State **automatically enrolls** beneficiaries

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

X The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

Response:

The DEPARTMENT determines Medicaid eligibility, and periodically the DEPARTMENT may reclassify a Member's Medicaid status from mandatory managed care coverage to non-managed care coverage. When the DEPARTMENT reclassifies a Member's coverage to non-managed care coverage, the Member's enrollment in managed care will end on the last day of the month.

The Department in conjunction with the enrollment broker, will review client requests for exemptions from enrollment into managed care plans. Exemptions will be granted on a case-by-case basis according to the guidelines listed below. All reasons for exemptions must be substantiated in order to obtain approval. Exemptions based on reasons 4 and 5 will be granted for as long as the conditions for exemption exist. All other exemptions will be granted on a temporary basis.

To obtain exemptions based on reasons 1-4, recipients must notify the enrollment broker of their intention to seek an exemption prior to enrollment. Based on the criteria listed below, the enrollment broker will seek any necessary documentation for review by CT-DSS or the enrollment broker. Final decision for exemption approvals rests with CT-DSS.

Exemptions will be granted for persons who:

1. are in advanced stages of terminal illness;
2. are in the last trimester of pregnancy and have an established relationship with an obstetrician who is not participating in HUSKY A;
3. are currently being treated for a medical problem by a doctor who is not participating in HUSKY A and changing doctors would cause more medical problems;
4. are receiving targeted case management from either the Department of Mental Health and Addiction Services or the Department of Mental Retardation

5. are hospitalized on the first day of enrollment;

The DEPARTMENT will exempt adults who receive SSI from managed care. The Member's enrollment in managed care will end on the last day of the month, and the exemption from managed care will occur the first day of the following month.

X The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Response: Re-enrollment into the same MCO occurs only when reinstated eligibility is made retroactive to when eligibility was first lost. The re-enrollment is also made retroactive to coincide with the eligibility dates.

d. **Disenrollment:**

X The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. X Enrollee submits request to State through its enrollment broker

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

___ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

X The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without

cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

X The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

i. X MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

Response: See contact section 3.25 copied below

3.25 Special Disenrollment

a. The MCO may request in writing and the DEPARTMENT may approve disenrollment of specific Members upon evidence of "good cause". The request shall cite the specific event(s), date(s) and other pertinent information substantiating the MCO's request. Additionally, the MCO shall submit any other information concerning the MCO's request that the DEPARTMENT may require in order to make a determination of "good cause".
b. Good cause is defined as a case in which a Member:
   1. Exhibits uncooperative or disruptive behavior. If, however, such behavior results from the Member's special needs, good cause may only be found if the Member's continued enrollment seriously impairs the MCO's ability to furnish services to either the particular Member or others; or
   2. Permits others to use or loans his or her membership card to others to obtain care or services.
c. The following shall not constitute good cause:
   1. Extensive or expensive health care needs;
   2. A change in the member's health status;
   3. The member's diminished mental capacity; or
   4. Uncooperative or disruptive behavior related to a medical condition except as described in b.1, above.
d. The effective date for an approved disenrollment shall be no later than the first day of the second (2nd) month following the month in which the MCO files the disenrollment request. If the DEPARTMENT fails to make the determination within this timeframe, the disenrollment shall be deemed approved.
e. The DEPARTMENT will notify an MCO prior to enrollment if a Member was previously disenrolled for cause from another MCO pursuant to this section.

For PCCM:

Special Disenrollment

a. The Provider may request in writing and the Department may approve disenrollment of specific Members upon evidence of "good cause" but only based upon evidence of good cause as defined in section (b) of this subsection. The request shall cite the specific event(s), date(s) and other pertinent information substantiating the Provider's request. Additionally, the Provider shall submit any other information concerning the Provider's request that the Department may require in order to make a determination of "good cause."

b. Good cause is defined as a case in which a Member exhibits uncooperative or disruptive behavior. If, however, such behavior results from the Member's special needs, good cause may only be found if the Member's continued enrollment seriously impairs the Provider's ability to furnish services to either the particular Member or others.

c. The effective date for an approved disenrollment shall be no later than the first day of the second (2nd) month following the month in which the Provider files the disenrollment request. If the Department fails to make the determination within this timeframe, the disenrollment shall be deemed approved.

d. The Department will notify the Provider prior to enrollment if a Member was previously disenrolled for cause from another PCCM Provider or MCO pursuant to this section.

ii. X The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
Response

The Department must determine whether or not "good cause" exists to approve an MCO or PCCM initiated disenrollment request.

iii. X If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. X The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. **Assurances.**

X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

X The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for MCO or PIHP programs**.

a. **Direct access to fair hearing**.

___ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

X The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

Response
The enrollee's appeal is a concurrent appeal to the MCO and the Department. The MCO appeal review is usually conducted prior to the Department's administrative hearing. A date for the administrative hearing is scheduled when the enrollee files an appeal. The Department's Fair hearing is used when the appeal to the MCO is not decided in the Member's favor or if the MCO does not make a decision prior to the hearing date.

b. **Timeframes**

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).

Response

The Member will lose his or her right to an appeal and administrative hearing if he or she does not complete and file a written appeal form with the DEPARTMENT within sixty (60) days from the date the MCO mailed the initial NOA;

X The State's timeframe within which an enrollee must file a **grievance** is 60 days.

c. **Special Needs**

___ The State has special processes in place for persons with special needs. Please describe.

Response

The Department in Sections 4.03 and 4.05 of the contract with the MCOs requires its MCOs to provide its enrollees opportunities to grieve or appeal MCO decisions. At a minimum the MCOs must overcome communication and other handicapping barriers that would prevent an individual with special needs from participating in the process. Furthermore, the MCO must address the enrollee's issues within a timeframe that is appropriate for the member's medical condition.

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in

instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

___ The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

___ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

___ Establishes and maintains an expedited review process for the following reasons:_____. Specify the time frame set by the State for this process____

___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO or PIHP programs**

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604

Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

MCO Monitoring

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data		MCO PCCM	MCO PCCM	MCO PCCM	MCO	MCO PCCM	MCO PCCM			MCO PCCM	MCO PCCM	MCO
Data Analysis (non-claims)			MCO PCCM			MCO PCCM		MCO PCCM	PCCM			MCO PCCM
Enrollee Hotlines	MCO PCCM	MCO PCCM	MCO PCCM		MCO PCCM		MCO PCCM		MCO PCCM		MCP PCCM	MCO PCCM
Focused Studies							MCO					MCO
Geographic mapping								MCO			MCO PCCM	
Independent Assessment	MCO	MCO	MCO	MCO PCCM	MCO	MCO	MCO	MCO	MCO PCCM	MCO	MCO	MCO PCCM
Measure any Disparities by Racial or Ethnic												MCO

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Groups												
Network Adequacy Assurance by Plan								MCO			MCO	
Ombudsman												
On-Site Review		MCO		MCO	MCO	MCO	MCO		MCO	MCO	MCO	MCO
Performance Improvement Projects							MCO			MCO		MCO PCCM
Performance Measures								MCO		MCO		MCO PCCM
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload				PCCM								PCCM
Provider Self-Report Data												
Test 24/7 PCP Availability												

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Utilization Review									MCO PCCM	MCO		MCO PCCM
Other: (describe)												
Marketing and Member Material Review by DSS		MCO PCCM			MCO PCCM							

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. __ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. __ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

c. X **Consumer Self-Report data**

X CAHPS (please identify which one(s) MCOs contract for CAHPS
___ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups
X Other (please describe): See #s 2, 3 and 4 below

1. *Consumer Assessment of Health Plan Survey (CAHPS):*

The Department requires the MCOs that participate with the CT State Medicaid Managed Care program, to commission and pay for an

annual Consumer Assessment of Health Plans Survey (CAHPS) using an independent NCQA certified vendor to measure a number of objectives, including but not limited to beneficiary (member) satisfaction. The MCOs provide the Department with an Adult Medicaid CAHPS survey and a Child Medicaid CAHPS survey or a combination of both. The survey includes a compilation of member ratings of their health plan overall, e.g., their contentment with health care provided, impressions regarding treatment given by personal doctors and specialists; and an assessment of member perceptions concerning customer service, obtaining needed care, receiving care quickly, and how well doctors communicate.

2. Affiliated Computer Services, Inc (ACS)

   The Department's enrollment broker operates a call center to counsel on and process MCO enrollment choices. ACS provides monthly reports to the Department regarding enrollment activity including the reasons clients change MCOs. ACS refers complaints or issues articulated by clients, such as potential marketing violations, misleading information, ability to access care, etc. to the Department.

3. HUSKY Infoline (HIL), a specialized unit of The United Way of CT /211 Infoline, serves as a statewide telephone resource providing health care information and advocacy for children and families enrolled in HUSKY. HIL tracks and reports barriers to eligibility, enrollment, and access to health care services in addition to other concerns expressed by members, such as potential marketing violations, misleading information, coverage or authorization issues, etc., to the Department on a semi-annual basis. Their work extends to both MCO and PCCM enrollees.

4. The Department also documents and tracks consumer inquiries and complaints received by the Department whether they are received directly from the HUSKY A clients, providers or through a third party. The Department has developed an Access database for this purpose. Summary reports will be produced on a semi-annual basis by Medicaid staff.

d. X Data Analysis (non-claims)

___ Denials of referral requests
_X_ Disenrollment requests by enrollee
  _√_ From plan [* also from PCCM]
  ___ From PCP within plan
_X_ Grievances and appeals data
_X__ PCP termination rates and reasons
_X_ Other (please describe)
- PCP panel size reports (MCO and PCCM)
- Data reported by PCCM on quality and coordination of care
- Case Management

- Prior Authorization

1. Disenrollment by enrollee from a Plan:

ACS processes and provides monthly enrollment and plan change reports. The reports include a variety of reasons a beneficiary chooses to switch MCOs. The report will also include information on enrollment and disenrollment to/from PCCMs.

2. Grievances and appeals data:

The Department contractually requires MCOs to maintain comprehensive adequate records to document the filing of a grievance, the actions taken, the MCO personnel involved and the resolution. Appeals and grievances are considered different in that an appeal is an expression of dissatisfaction with the MCO decision on an action taken with regard to a health service (or goods). Whereas a grievance is an expression of dissatisfaction with the MCO on any matter other than an action. MCOs will be submitting these reports to the State on a quarterly basis.

The Department tracks appeal activity. There are two levels of an appeal. The MCO is responsible for the first level of appeal in which the MCO re-examines the original action taken. The second level of appeal is the responsibility of the Department in the Office of Legal Counsel, Regulations, and Administrative Hearings (OLCRAH) unit.

MCOs use mandatory Notice of Action (NOA) templates developed by the Department to act on authorization decisions set forth in the contract within the required timeframes.

Although MCOs maintain a system to capture and track appeal requests received from HUSKY A members, the State will be conducting its own tracking, monitoring and reporting related to appeals. The State has developed an Appeals and Hearings Access database for this purpose. The appeal is first documented in the database upon receipt by the State and tracked throughout the appeal and administrative hearing process.

State staff will produce summary semi-annual reports including information as to the types of services that were denied, reduced or terminated, number of appeals by service type, outcomes of the appeals at appeal review level and administrative hearing level and outcomes of the appeals by service type.

For PCCM, appeals will take place through the same process used in our fee-for-service Medicaid program and will be tracked and reported through the same process described above for MCOs. Grievances will be received directly by the PCCM PCPs or through HUSKY Infoline and transferred to the appropriate Department staff. Department staff will monitor and track grievances in a database, and work to resolve grievances. Reporting will be done by State staff on a semi-annual basis.

3. PCP Termination Rates and Reasons

On a semi-annual basis, MCOs are required to submit provider turnover reports to the Department. The reports will also quantify the number of providers voluntarily terminating from the MCO versus those terminated by the MCO.

4. PCP/Specialist Capacity

On a quarterly basis the Department receives a PCP panel report from each MCO. The report identifies the number of enrollees who are assigned to specific PCPs. Data on PCCM enrollment per PCP will be received more frequently, at a minimum of monthly. The Department consolidates the reports by provider from all MCOs and PCCMs to arrive at a grand total. If a provider has 1200 or more enrollees assigned to him/her from all sources, the Department notifies the MCOs that have enrolled that provider. The MCO must then certify to the Department that the enrollees of those providers with more than 1200 enrollees do not experience access limitations. If the MCO can not certify to the Department that enrollees do not experience access problems, the MCOs must sufficiently redistribute enrollees among their PCP panels to eliminate the access problems.

5. Coordination/Continuity and Quality of Care

PCCMs will be required to collect and report a variety of process and outcomes data that cannot be obtained from claims. For example, they will report on EPSDT completion and completion of the personal risk assessment for all PCCM members. These data will be reported to and monitored by the Department on a semi-annual basis. Additionally, PCCMs are required to have an electronic medical record or electronic disease management data registry by the end of the first year of the program. Data from these systems will be used by the Department to evaluate the care received by PCCM members.

6. Case Management

MCOs are required to submit semi-annual reports to the Department of members receiving case management services, with diagnosis (i.e. reason fro receiving case management).

7. Prior Authorization

MCOs are required to submit semi-annual summary reports to the Department of prior authorizations received, denied and reasons for denials.

e. X Enrollee Hotlines operated by State

HUSKY A members have access to a toll free hotline which, depending on the option chosen will connect them with ACS, the enrollment broker or Husky Infoline (HIL). The hours of availability for both call centers are Monday – Friday 8:00 AM until 8:00 PM and Saturdays 10:00 AM until 2:00 PM. These hotlines are for all HUSKY enrollees, whether in MCOs or PCCM.

1. *ACS:*

ACS – Affiliated Computer Services, Inc (ACS), the Department's enrollment broker, operates a call center to handle requests for HUSKY applications and inquiries about eligibility guidelines. They also counsel enrollees on enrollment choices and process the MCO enrollment choices. ACS provides monthly reports to the Department regarding call center activity, such as application volume as well as enrollment activity; including the reasons clients change MCOs. Additionally, ACS refers other inquiries or complaints to the Department for follow-up and tracking.

2. *HUSKY Infoline:*

The Department contracts with HUSKY Infoline, a specialized unit of United Way of CT 211/Infoline, to serve as a statewide telephone resource providing health care information and advocacy for children enrolled in HUSKY managed care plans. Care Coordinators advocate for clients who need help accessing health care services, scheduling appointments or resolving billing issues. They answer questions about covered services including the EPSDT (Early Periodic Screening, Diagnosis, and Treatment) Program. HIL tracks and reports barriers to eligibility and enrollment as well as access to health care services to the Department on a semi-annual basis. HIL also tracks other concerns expressed by members, such as potential marketing violations, misleading information, coverage or authorization issues, etc. Issues or complaints which require Department intervention or follow-up, such as contract compliance issues, are referred to Department staff.

f. X **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

State staff will conduct focused studies of areas of interest identified with input from the Medicaid Managed Care Council (MMCC) and MMCC subcommittees. The MMCC is a legislative advisory council with representatives from various stakeholders, including legislators, health care providers, other State agencies, consumers, the HUSKY MCOs and client advocates. The MMCC and its subcommittees meet monthly. Medicaid staff attends and participates in all MMCC and subcommittee meetings. It is anticipated that some areas of interest for which focused

studies may be considered include emergency department utilization, pre-natal care; depression screening and asthma prevalence.

g. X Geographic mapping of provider network

The Department requires that each MCO ensure geographic access of providers for program members. MCOs utilize geo-mapping for this purpose. The Department will also be conducting geo-mapping analysis of the MCO provider networks on a semi-annual basis.

For PCCM, the Department has mapped the locations of applicant PCPs, and is only opening the program with providers in concentrated areas that have a mix of PCCMs available for both adults and children.

h. X Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods)

i. X Measurement of any disparities by racial or ethnic groups

Measurement of racial or ethnic disparities will be incorporated into at least one of the focused studies that will be conducted during the course of the two-year waiver.

j. X Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]

On at least a quarterly basis the Department evaluates the adequacy of the MCOs provider network by calculating the ratio of enrollees to primary care providers per county per MCO. The Department establishes a maximum enrollment level in each county factoring in the number of providers participating in each plan. The Department compares the enrollment to the maximum capacity to ensure that the capacity is not exceeded. The Department issues a warning to the Plans when the number of enrollees in a particular county reaches 90% of capacity. When an MCO's enrollment reaches or exceeds full capacity in a given county, the MCO has thirty days to increase the number of providers available that county, If the MCO is not successful in enrolling a sufficient number of providers, enrollment is frozen until the MCO can demonstrate that they have enrolled a sufficient number of providers. This measure assists the Department in gauging a member's access to primary medical services in their county. The Department measures access to specialists by examining and reviewing complaints received by the Department, MCOs, ACS, and HIL.

k. __ Ombudsman

l. X **On-site review**

The State's External Quality Review Organization (EQRO) conducts an on-site review for each MCO annually. The EQR site visits are preceded by a desk reviews of MCO polices and procedures and other documentation submitted by the MCO to the EQRO.

The EQRO issues findings from the review each MCO as well as a summary report. Each MCO is required to submit a Corrective Action Plan describing their methodology to correct deficiencies.

m. X **Performance Improvement Projects** [**Required** for MCO/PIHP]

_X__ Clinical
_X__ Non-clinical

MCOs are required to conduct a minimum of four (4) performance improvement projects (PIPs), with at least two of the four having a focus on two of the following areas:

- Prevention and care of acute and chronic conditions
- High volume services
- Continuity and coordination of care
- Appeals, grievances and complaints
- Access to and availability of services

The MCOs must also conduct a minimum of two PIPS required by the Department. Each PIP should be considered reliable and valid with the confidence in reported results and ongoing improvement opportunity over a three year course of time. The EQR annual reviews include reviews of a selected number of PIPs from each for reliability and validation of reported results.

In PCCM, quality improvement initiatives will be developed with input from the provider advisory committee. The source of data for these initiatives may be from claims (as analyzed by the Department), and from data gathered by the PCCM. For example, PCCMs are required to identify (with data support from the Department) inappropriate high costs and high users for the purpose of developing and implementing activities that lower inappropriate utilization and cost. Additionally, PCCMs must review emergency department utilization data of their members, and integrate appropriate outreach, follow-up, and education of their members.

n. X **Performance measures** [**Required** for MCO/PIHP]

Process
Health status/outcomes

MCOs submit at minimum, semi-annually, to the Department various utilization and other reports for the purpose of supporting the Department in its efforts to evaluate the use of services, health care status and to

measure the overall performance of the MCOs. Validation of performance measures by the EQRO includes review of MCO reporting methodology to ensure compliance with State specifications. The EQRO also calculates selected performance measures for each MCO. Similar utilization and other reports for PCCM will be developed by the Department.

o. _____ **Periodic comparison of number and types of Medicaid providers before and after waiver**

p. _X_ **Profile utilization by provider caseload** (looking for outliers)

The Department will gather and analyze data annually relating to service utilization by PCCM members to determine whether providers are within acceptable PCCM peer comparison parameters.

q. _____ **Provider Self-report data**

___ Survey of providers

___ Focus groups

r. __ **Test 24 hours/7 days a week PCP availability**

s. X **Utilization review** (e.g. ER, non-authorized specialist requests)

The Department requires MCOs to submit semi-annual utilization reports covering the following areas: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and participation ratios, vision exams, eyeglasses, non emergency transportation, inpatient utilization, emergency department utilization, adult preventive care and maternity/prenatal care and outcomes reports. Additional routine reporting from the MCOs includes Case Management and Prior Authorization.

The Department will also utilize encounter data from the MCOs and claims data for the carved-out services to review utilization of various services of interest as well reviewing utilization across services provided by the MCOs and the carved-out services.

For PCCM, similar reports on many of these areas, such as EPSDT, inpatient utilization, emergency department utilization, and adult preventive care, will be created by the Department using claims data.

t. X **Other**: (please describe)

1. Marketing and Member Material Review

The Department reviews all MCO materials related directly to HUSKY beneficiaries including but not limited to: member handbook, member welcome package, provider directory, health education and administrative information. The Department also reviews all information MCOs present

to the general public that mentions HUSKY using Departmental marketing guidelines to follow compliance.

The Department contractually requires that MCO specific materials (all media) and give–a-ways targeting the HUSKY population obtain prior approval. The Department checks for accurate promotion, misleading or exaggerated claims, discrimination as well as deceptive practices. MCOs are not permitted to actively solicit new enrollees at provider sites and at the Department's regional offices. The MCO may market their managed care plan, or conduct community outreach at events and meetings open to the general public.

Also, the Department requires the MCOs to submit annual marketing plans and revisions to such plans, including description of proposed marketing approaches and procedures for the Department's review and approval.

For PCCM, the Department similarly requires review and prior approval of marketing materials, member welcome packets, and other HUSKY-specific materials. The marketing guidelines, which PCCMs contractually agree to follow, are similar to those for MCOs – with some differences based on the nature of the program. For example, general health education materials used by PCCMs do not require the Department's review. Much of the information to beneficiaries, such as initial enrollment information, will be created by the Department itself.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

_X_ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

___ This is a renewal request.

- ___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ___ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ Yes

___ No. Please explain:
Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual

Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: **Lee Voghel**

c. Telephone Number: **(860) 424-5842**

d. E-mail: **Lee.Voghel@ct.gov**

e. The State is choosing to report waiver expenditures based on
X date of payment.
__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a. X MCO
b. ___ PIHP
c. ___ PAHP
d. ___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. X Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1. X First Year: **$ 7.50** per member per month fee
   2. X Second Year: **$ 7.50** per member per month fee
   3. ___ Third Year: $____ per member per month fee
   4. ___ Fourth Year: $____ per member per month fee

b. ___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

Certain performance indicators, considered by Connecticut to be especially significant to either the quality of treatment or efficiency of administration of the PCCM system, may be selected annually as indicators to which either incentives or disincentives will be attached in future years of the program. The State will modify the waiver at renewal to outline the specific criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, the monitoring the State will have in place to ensure that total payments do not exceed cost-effectiveness, and the safeguards to ensure that utilization is not adversely affected due to incentives inherent in the bonus payments.

d. ___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. ***Appendix D1 – Member Months***

Please mark all that apply.

For Initial Waivers only:

a. **X** Population in the base year data
   1. **X** Base year data is from the same population as to be included in the waiver.
   2. ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. ___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c. **X** [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

The State's projections for P1 and P2 include increases attributable to past expanded outreach efforts in addition to various expansions for Medicaid eligibility beginning in the middle and/or after the base year of CY2007.

- Effective July 1, 2007 eligibility for HUSKY A parents and caregivers increased from 150 percent of the Federal Poverty Level (FPL) to 185 percent FPL.

- Effective March 1, 2008 uninsured newborns will be enrolled in HUSKY A at birth.

- Effective January 1, 2008 eligibility for pregnant women increased from 185 percent FPL to 250 percent FPL.

The full effects of the earlier expansion HUSKY A population was not experienced during the base year. All of the effect of the pregnant women and newborn expansions occurred after the base year concluded. The combined annualized impact of these changes results in an additional 3.65% for MM growth to the CY2007 MEG in P1. The magnitude of these changes have a lesser impact on the projected enrollment growth for P2 as these populations stabilize in the HUSKY A program.

d. X [Required] Explain any other variance in eligible member months from BY to P2: The State includes projected enrollment decreases in July of each year attributable to an annual redetermination process.

e. X [Required] List the year(s) being used by the State as a base year: Calendar Year 2007 (CY07). If multiple years are being used, please explain:_____

f. X [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. The base year reflects a calendar year time period.

g. X [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

The base year is derived from actual 2007 CMS-64 experience from the State's previously approved 1915(b) managed care waiver (primarily prior to the implementation of the non-risk PIHP program).

The State currently has an approved extension of its Waiver authority through June 30, 2009. Through discussions with both the CMS Central Office staff and the Boston Regional Office staff, the State is to submit an Initial Waiver, rather than a Renewal Waiver, utilizing calendar year 2007 as the base year. For the majority of CY07, the HUSKY A program reflected a full risk capitated managed care reimbursement system. Because of this, CMS-64.9 Waiver and CMS-64.10 Waiver forms for CY07 are utilized as the expenditure data for the base year.

For Conversion or Renewal Waivers:

a.___ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

_____

d. ___ [Required] Explain any other variance in eligible member months from BY/R1 to P2: ____

e.____[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

All services identified on Appendix D2.S are included in the cost-effectiveness analysis. Two services (pharmacy and dental) are reclassified from being reported in the MCO capitation rate to being paid on a fee-for-service impacted basis:

- Effective February 1, 2008, the state began paying most pharmacy services on a fee-for-service basis outside of the managed care capitation rate.
- Effective September 1, 2008, the state began paying most dental services on a fee-for-service basis outside of the managed care capitation rate.

Hospice is anticipated to be added as a new state plan service with a target effective date of July 1, 2009. This service will be reimbursed on a fee-for-service basis as reflected on Appendix D2.S.

For Conversion or Renewal Waivers:

a.___ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

_____

b.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: _____

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great

enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

The base year is derived from actual 2007 CMS-64 experience from the State's previously approved 1915(b) managed care waiver (primarily prior to the implementation of the non-risk PIHP program). The State's base year costs including administration under the new waiver will be cost effective compared to its previous waiver program projections. The State has included its previous waiver projections in Appendix D7 compared to its base year costs for this reason.

Additionally, as previously identified in Section D.I..E.g. for Initial Waivers, the State currently has an approved extension of its Waiver authority through June 30, 2009. Through discussions with both the CMS Central Office staff and the Boston Regional Office staff, the State is to submit an Initial Waiver, rather than a Renewal Waiver, utilizing calendar year 2007 as the base year. For the majority of CY07, the HUSKY A program reflected a full risk capitated managed care reimbursement system. Because of this, Appendix D2.A will reflect the administrative expenditure data from CY07 as reported on the CMS-64.10 Waiver forms.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Independent assessment for first two Waiver periods.	*The base year is derived from actual 2007 CMS-64 experience from the State's previously approved 1915(b) managed care waiver (primarily prior to the implementation of the non-risk PIHP program). Through discussions with both the CMS Central Office staff and the Boston Regional Office staff, the State is to submit an Initial Waiver, rather than a Renewal Waiver, utilizing calendar year 2007 as the base year. For the majority of CY07, the HUSKY A program reflected a full risk capitated managed care reimbursement system. Because of this, Appendix D2.A will reflect the administrative expenditure data from CY07 as reported on the CMS-64.10 Waiver forms. The description of the Independent Assessment is unique because this is a submission for an initial waiver for a waiver program that currently has an*	*Not applicable.*	*$100,000 or approximately $0.02 PMPM*

	approved waiver authority.		
Total			*No specific adjustment was made because this amount has an immaterial impact on the overall results.*

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.__X__ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5.**

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period

Not applicable.			
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		***(PMPM in Appendix D5 Column W x projected member months should correspond)***

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	$1,751,500 or $.97 PMPM R1 $1,959,150 or $1.04 PMPM R2 or BY in Conversion	8.6% or $169,245	$2,128,395 or 1.07 PMPM in P1 $2,291,216 or 1.10 PMPM in P2.

Total	***(PMPM in Appendix D3 Column H x member months should correspond)***		***(PMPM in Appendix D5 Column W x projected member months should correspond)***

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c.__X__ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.__X__ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

The State requires prior notification from the MCOs as to their intent to purchase or modify reinsurance protection, but does not require MCOs to purchase private reinsurance coverage. The risk analysis, assumptions, cost estimates and rationale supporting the proposed reinsurance arrangement is required for prior approval by the State.

2.___ The State provides stop/loss protection (please describe):

d.____Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.
iv. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include

information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

Only adjustments necessary for a renewal waiver are made in this initial renewal because the source of the base year data is an approved 1915(b) waiver CMS-64 form. Therefore, the base year expenditures appropriately reflect the waiver program adjustments. This eliminates many of the base year adjustments that are described in this section of the waiver pre-print since the projected expenditures in P1 and P2 are built upon a base year that reflects a full risk capitated managed care environment.

The State currently has an approved extension of its Waiver authority through June 30, 2009. Through discussions with both the CMS Central Office staff and the Boston Regional Office staff, the State is to submit an Initial Waiver, rather than a Renewal Waiver, utilizing calendar year 2007 as the base year. For almost all of the base year time period (CY07), the HUSKY A program reflected a full risk capitated managed care reimbursement system. Because of this, CMS-64.9 Waiver and CMS-64.10 Waiver forms for CY07 will be utilized as the expenditure data for the base year.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

   1. ___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: ____. Please document how that trend was calculated:

   2. _X_ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. X State historical cost increases. Please indicate the years on which the rates are based: base years Trend rates were developed from multiple time periods from July 1, 2003 through June 30, 2007. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

Annual trend factors for medical inflation were derived using information from various data sources while using both quantitative data and qualitative estimates. General regression techniques were applied to MCO financial cost data that included monthly cost information captured in financial lag data. Forty-eight months of incurred HUSKY A MCO financial data through June 2007, were completed, adjusted and analyzed. Historical HUSKY A encounter data covering incurred dates of service from July 2005 through June 2007, were also analyzed.

These encounter and financial trend estimates were reviewed and compared to trends from several other sources, including other states' Medicaid programs, Consumer Price Index (CPI) medical trends, Data Resources Incorporated (DRI) trends, state specific budget information and general health care industry trends

Separate, mutually exclusive adjustments were calculated to account for changes in utilization that are anticipated to take place as a result of the respective carve-outs – see program adjustments below.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
ii. Please document how the utilization did not duplicate separate cost increase trends.

b. X **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. X An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv.___ Changes in legislation (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v. X Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. X Other (please describe):

The state reviewed the impact of various programmatic changes that could influence the ultimate annualized trends used for rate development purposes. These programmatic changes could impact either the base data that was analyzed for trend purposes or the projected prospective annualized trends developed for rating purposes. Various program changes, such as mandated changes to the Medicaid fee schedules and reimbursement rates and changes to benefits or eligibility requirements were reviewed when determining the final annual category of service specific trends.

Although the pharmacy and dental health services delivery system has changed from a fully capitated system to a fee-for-service delivery system, unit cost trends were not assumed to change because of this shift. Mutually exclusive adjustments were made to account for anticipated changes in the utilization of both pharmacy and dental services as a result of the carve-outs. It is estimated that pharmacy utilization will increase 10.0% and dental utilization will increase 25.0%.

Other adjustments reflect various changes in benefits, eligibility or reimbursement methods that became effective after the base year period. These adjustments are incorporated into the P1 projections and are described as follows:

- Including the full encounter rate for covered services delivered at Federally Qualified Health Centers in the MCO's capitation payment rates. Previously, the FQHC wrap-around settlement payment was paid outside of the managed care capitation rate. This adjustment moves expenditures from being identified as fee-for-service expenditures to MCO capitated expenditures per approved CMS guidance.
- Providing routine dental examinations performed by primary care physicians.
- Adding hospice as a state plan service. This service will be reimbursed on a fee-for-service basis.
- Changes in acuity due to expanding HUSKY A eligibility to pregnant women up to 250 percent FPL. The overall cost for a pregnant woman is assumed to remain consistent for this expansion population, however having more pregnant woman enrolled in the program results in an overall increase to the observed per member per month cost.
- Changes in acuity due to expanding HUSKY A eligibility to uninsured newborns. The overall cost for a newborn is assumed to remain consistent for this expansion population, however having more newborns enrolled in the program results in an overall increase to the observed per member per month cost.
- Incorporating a retrospective capitation rate increase impacting the second half of the base year period.

It is assumed that savings generated by the PCCM pilot program will offset the PCCM case management fees, additional administration costs, and anticipated increases to utilization. The savings is assumed to be generated by eliminating the MCO non-medical load built into the capitation rates.

The overall net impact of these adjustments is 12.76%.

c. X **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population

participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2. X An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

ii. X FFS cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. X Other (please describe):

The base year is derived from actual 2007 CMS-64 experience from the State's previous approved 1915(b) managed care waiver (primarily prior to the implementation of the non-risk PIHP program). The State's base year costs including administration under the new waiver will be cost effective compared to its previous waiver program projections. Connecticut has included its previous waiver projections in Appendix D7 compared to its base year costs for this reason.

Changes in the administration of the waiver population are reflected in the adjustments described in this section. These changes include adjustments to the historical base year administrative expenditures to develop projected expenditures appropriate for the P1 and P2 time periods as are appropriate for any trend of a renewal waiver.

Additional fee-for-service administrative expenditures are incorporated to account for the required dental

administrative contractor to administer the shift of dental benefits to fee-for-service.

It is assumed that savings generated by the PCCM pilot program will offset the PCCM case management fees, additional administration costs, and anticipated increases to utilization. The savings is assumed to be generated by eliminating the MCO non-medical load built into the capitation rates.

The impact of these adjustments are incorporated in the trend reflected in the waiver appendices.

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

Not applicable.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present)*. The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a**

_____

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.__X__ We assure CMS that GME payments are excluded from base year data..

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1. X Payments outside of the MMIS were made. Those payments include (please describe):

Wrap-around settlement payments to FQHC's are included in the base year data as service expenditures to reflect a change in procedure to pay settlements through the capitation rates according to approved CMS policy.

Effective no later than September 1, 2009, it is anticipated that FQHC's will bill and be reimbursed by the State's fiscal intermediary EDS. This would result in a projected budget neutral shift of expenditures from the MCO capitated rate to fee-for-service.

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. X Other (please describe):

No adjustment was necessary since the base year data appropriately reflects the waiver program in P1 and P2.

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1.**X** No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
   i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter

drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3. X Other (please describe):

Effective February 1, 2008, the State began paying most pharmacy services on a fee-for-service basis outside of the managed care capitation rate. During the base year, pharmacy services net of rebates were included in the MCO capitation rate. Projected pharmacy expenditures in P1 and P2 are reduced to reflect the greater anticipated pharmacy rebates to be obtained by the State in FFS.

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. X We assure CMS that DSH payments are excluded from base year data.
2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. X This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.___ This adjustment was made:
   a. ___Potential Selection bias was measured in the following manner:
   b. ___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3. X Other (please describe):

Wrap-around settlement payments to FQHC's are included in the base year data as service expenditures according to approved CMS policy.

Effective no later than September 1, 2009, it is anticipated that FQHC's will bill and be reimbursed by the State's fiscal intermediary EDS. This would result in a projected budget neutral shift of expenditures from the MCO capitated rate to fee-for-service.

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your

calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

Only adjustments necessary for a renewal waiver are made in this initial renewal because the source of the base year data is an approved 1915(b) waiver CMS-64 form. Therefore, the base year expenditures appropriately reflect the waiver program adjustments. This eliminates many of the base year adjustments that are described in this section of the waiver pre-print since the projected expenditures in P1 and P2 are built upon a base year that reflects a full risk capitated managed care environment.

It is assumed that savings generated by the PCCM pilot program will offset the PCCM case management fees, additional administration costs, and anticipated increases to utilization. The savings is assumed to be generated by eliminating the MCO non-medical load built into the capitation rates.

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.
Documentation of assumptions and estimates is required for this adjustment.

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner

on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2. X The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2. X This adjustment was made in the following manner:

It is assumed that savings generated by the PCCM pilot program will offset the PCCM case management fees, administration costs, and anticipated increases to utilization. The savings is assumed to be generated by eliminating the MCO non-medical load built into the capitation rates.

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. X No adjustment was made.

2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver

program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

   1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

   2.___ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

      i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not

collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

c.___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii.___ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs

trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present)*. The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates
   1. Please indicate the years on which the rates are based: base years_____
   2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend
   1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.**

_____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
   1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

   2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

   3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

State of Connecticut

Appendix D1. Member Months

Row # / Column Letter | B | C | D | E | F | G | H | I | J | K | L | M | N

Estimated Member Month Calculations

State of Connecticut

Enrollment Projections for the Time Period 7/1/09 - 6/30/11

Medicaid Eligibility Group (MEG)	All Regions											
	Base Year (BY) CY2007	Projected Quarter 1 begins 7/1/2009	Projected Quarter 2 begins 10/1/2009	Projected Quarter 3 begins 1/1/2010	Projected Quarter 4 begins 4/1/2010	Projected Year 1 (P1)	Projected Quarter 6 begins 7/1/2010	Projected Quarter 6 begins 10/1/2010	Projected Quarter 7 begins 1/1/2011	Projected Quarter 8 begins 4/1/2011	Projected Year 2 (P2)	Total Projected (H+M)
MEG 1	3,602,566	1,075,239	1,099,585	1,123,968	1,148,130	4,446,922	1,171,050	1,193,975	1,216,711	1,239,582	4,821,318	9,268,240
MEG 2												
MEG 3												
MEG 4												
Total Member Months	3,602,566	1,075,239	1,099,585	1,123,968	1,148,130	4,446,922	1,171,050	1,193,975	1,216,711	1,239,582	4,821,318	9,268,240
Quarterly % Increase			2.3%	2.2%	2.1%		2.0%	2.0%	1.9%	1.9%		
Annualized % Increase Base Year to Year 1 to Year 2						8.8%					8.4%	

Modify Line items as necessary to fit the MEGs of the program.

State Completion Sections

Row # / Column Letter

Services in Actual Waiver Cost (Comprehensive)
State of Connecticut
Base Year Initial Waiver

State Plan Services					
Service Category	State Plan Approved Services	1915(b)(3) Services	MCO Capitated Reimbursement	FFS services Impacted by MCO	PCCM Fee-for Service Reimbursement
Birth to Three Services	X			X	X
Chiropractic Services up to age 20	X		X		X
Christian Science Sanitoria	X		X		X
Dental Services	X			X	X
Diagnostic Services	X		X		X
Dialysis	X		X		X
Durable Medical Equipment	X		X		X
Emergency Services	X		X		X
EPSDT Screening	X		X		X
Family Planning Services	X		X		X
FQHC Services	X		X		X
Home Health Services	X		X		X
Hospice	X			X	X
Immunizations	X		X		X
Inpatient Hospital - Other	X		X		X
Inpatient Hospital - Psych	X			X	X
Inpatient Substance Abuse Services[1]	X			X	X
Lab and X-ray	X		X		X
Medical Surgical Supplies	X		X		X
Mental Health Services	X			X	X
Naturopathic Services up to age 20	X		X		X
Nurse Midwife	X		X		X
Nurse Practitioner	X		X		X
Nursing Facility	X		X		X
Obstetrical Services	X		X		X
Orthotics and Prosthetics	X		X		X
Outpatient Hospital - All Other	X		X		X
Outpatient Hospital - Lab & X-ray	X		X		X
Pharmacy	X			X	X
Psychologist Services up to age 20	X			X	X
Physical Therapy up to age 20	X		X		X
Physician Services	X		X		X
Podiatry up to age 20	X		X		X
Prof. & Clinic and other Lab & X-ray	X		X		X
Rehabilitation Treatment Services[2]	X		X		X
School Based Child Health	X			X	X
School Based Clinic	X		X		X
Speech Therapy	X		X		X
Transportation - Emergency	X		X		X
Transportation - Non-Emergency	X		X		X
Vision Exams and Glasses	X		X		X

Notes:

1. MCO's are responsible for Alcohol Detoxification on a medical floor.

2. MCO's are responsible for Rehabilitation Treatment Services except those that are payable under the CT Behavioral Heath Program.

FFS Administration in Actual Waiver Cost (Comprehensive)
State of Connecticut
Base Year Initial Waiver

Row # / Column Letter	B	C	D	E	F
					Detail from Schedule F
7	CMS 64.10 line Item	CMS 64.10 Explanation	Contract	Match Rate	BY Expenses
8	1	FAMILY PLANNING		90% FFP	
9	2	DESIGN DEVELOPMENT OR INSTALLATION OF MMIS*		90% FFP	
10	A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		90% FFP	
11	B.	COST OF PRIVATE SECTOR CONTRACTORS		90% FFP	
12	C.	DRUG CLAIMS SYSTEM		90% FFP	
13	3	SKILLED PROFESSIONAL MEDICAL PERSONNEL		75% FFP	
14	4	OPERATION OF AN APPROVED MMIS*:		75% FFP	
15	A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		75% FFP	
16	B.	COST OF PRIVATE SECTOR CONTRACTORS		75% FFP	
17	5	MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES:		50% FFP	
18	A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		50% FFP	$ 431,502
19	B.	COST OF PRIVATE SECTOR CONTRACTORS	EDS, First Data	50% FFP	$ 353,728
20	6	PEER REVIEW ORGANIZATIONS (PRO)	Qualidigm, Mercer	75% FFP	$ 1,135,907
21	7. A.	THIRD PARTY LIABILITY RECOVERY PROCEDURE - BILLING OFFSET		50% FFP	$ -
22	B.	ASSIGNMENT OF RIGHTS - BILLING OFFSET		50% FFP	$ -
23	8	IMMIGRATION STATUS VERIFICATION SYSTEM COSTS		100% FFP	$ -
24	9	NURSE AIDE TRAINING COSTS		50% FFP	$ 365
25	10	PREADMISSION SCREENING COSTS		75% FFP	$ 236
26	11	RESIDENT REVIEW ACTIVITIES COSTS		75% FFP	$ -
27	12	DRUG USE REVIEW PROGRAM		75% FFP	$ -
28	13	OUTSTATIONED ELIGIBILITY WORKERS		50% FFP	$ -
29	14.	TANF BASE		90% FFP	$ -
30	15.	TANF SECONDARY 90%		90% FFP	$ 97,504
31	16.	TANF SECONDARY 75%		75% FFP	$ 463,795
32	17.	EXTERNAL REVIEW		75% FFP	$ -
33	18.	ENROLLMENT BROKERS	ACS	50% FFP	$ 4,276,335
34	19.	OTHER FINANCIAL PARTICIPATION	UConn OSD, Center For Medicare Advocacy, Postage & Printing, Communications, IKON Solutions, Schramm Raleigh, ACS, Misc Hospital Health Screens, DSS Regional Office Misc Expenses, Towns, United Way of CT, CRT, Allied Community Resources, CT Association for Community Action, DOIT, Mercer, Lubitsky, Colonial Cooperative Care, CT Childrens Health, Value Options, NEMT Services	50% FFP	$ 15,601,280
35	20	Total			**$ 22,360,652**

36

37 *Allocation basis is _X_% of Medicaid costs OR ___ % of Medicaid eligibles OR ___ other, please explain:

38 Add multiple line items as necessary to fit the administration of the program (i.e. if you have more than one contract on line 19, detail the contracts separately).

39 State Completion Sections Enter in amounts from Schedule F on the MBES system.

Appendix D3. Actual Waiver Cost

Actual Waiver Cost Initial Waiver Comprehensive Version
State of Connecticut

Row # / Column Letter	B	C	D	E	F	G	H	I	J
7			Base Year (BY) Aggregate Costs						
8	Medicaid Eligibility Group (MEG)	Base Year Member Months	MCO/PIHP Capitated Costs (including incentives and risksharing payouts/withholds or PCCM Case Management Fees) (0 in initial waiver unless converting voluntary to mandatory)	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, provide documentation)	1915(b)(3) service costs (will be 0 in Initial Waiver)	Administration Costs (Attach list using CMS 64.10 Waiver schedule categories)	Total Actual Waiver Costs (F+G+H+I)
13	MEG 1	3,602,566	$ 695,567,137	$ 147,551,776	$ 843,118,913			$ 22,360,652	$ 865,479,565
14	MEG 2	-			$ -				$ -
15	MEG 3	-			$ -				$ -
16	MEG 4	-			$ -				$ -
17	Total	3,602,566	$ 695,567,137	$ 147,551,776	$ 843,118,913	$ -	$ -	$ 22,360,652	$ 865,479,565
18	BY Overall PMPM for BY (BY MMs)								

Modify Line items as necessary to fit the MEGs of the program.
State Completed Sections

Appendix D3. Actual Waiver Cost

Row # / Column Letter | B | C | K | L | M | N | O

Actual Waiver Cost Conversion Initial Comprehensive Version
State of Connecticut

Medicaid Eligibility Group (MEG)	Base Year Member Months	Base Year (BY) Per Member Per Month (PMPM) Costs				
		State Plan Service Costs (F/C)	Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)	Total Actual Waiver Costs (J/C)
MEG 1	3,602,566	$ 234.03	$ -	$ -	$ 6.21	$ 240.24
MEG 2	-					
MEG 3	-					
MEG 4	-					
Total	3,602,566					
BY Overall PMPM for BY (BY MMs)		$ 234.03	$ -	$ -	$ 6.21	$ 240.24

Modify Line items as necessary to fit the MEGs of the program.
State Completion Sections

Row # / Column Letter | B | C | D

Adjustments and Services in Waiver Cost Projection (Comprehensive)
State of Connecticut
Prospective Years 1 and 2 (P1 and P2)
Intial Waiver

Adjustments to the Waiver Cost Projection	Adjustments Made	Location of Adjustment
Base Period	X	The base period, illustrated in Appendix D3. reflects the period January 1, 2007 to December 31, 2007. Note the base period includes only State Plan Approved services. No 1915(b)(3) services or incentive payments are included in the Connecticut HUSKY A Program.
State Plan Trend	X	Appendix D5. Waiver Cost Projection, column J. For trend from the BY to P1 an annual trend of 7.6 percent, was used. An annual trend rate of 6.6 percent was used from P1 to P2.
State Plan Programmatic/policy/pricing changes	X	Appendix D5. Waiver Cost Projection, column P. Program changes include the following:

13			An adjustment was made to projected MCO capitation expenditures to account for changes to the Medicaid fee schedules, to incorporate an HPV vaccination, mandated floor level of reimbursement for HUSKY A providers, inclusion of the full encounter rate for Federally Qualified Health Centers (FQHC) in the MCO's at-risk capitation rates where the payment now includes the FQHC wrap-settlement payment that was previously paid by the State, the inclusion of hospice services not previously covered under the State Plan, routine dental examinations now performed by primary care physicians, expansion of eligibility for pregnant women up to 250 percent of FPL and expansion of eligibility for HUSKY A parents and caregivers up to 185 percent of FPL, and an adjustment to reflect retrospective payment increases that were implemented after the BY period. The impact of these respective programmatic changes are located in columns L through O.
14	Administrative Cost Adjustment	X	Appendix D5. Waiver Cost Projection, column AC. Administration expenditures were allocated to the Waiver based on the percentage of Waiver dollars to the Total Medicaid dollars. Adjustments to the administration expenditure projections for P1 and P2 include an increase to account for the establishment of a dental administrative contractor. Because Appendix D5 does not include a column for a programmatic change for projected administrative costs, the impact is reflected in the trend. The overall annualized administration trend including the impact of the dental carve-out is 8.8% for P1 and 2.8% for P2
15			
16			
17	1915(b)(3) service Trend	N/A	
18	Incentives (not in cap payment) Adjustments	N/A	
19	Other	X	1) PY1 is based on BY (CY07) and projected for 30 months. 2) Trend increases illustrated in all appendices between the base year and P1 represents the average annual difference across the 30 month time period.
20			

Appendix D5. Waiver Cost Projection

Row # / Column Letter

Waiver Cost Projection Initial Comprehensive Version
State of Connecticut
Note: Complete this Appendix for all Prospective Years
Waiver Cost Projection

Medicaid Eligibility Group (MEG)	Base Year (BY) Member Months	Base Year Per Member Per Month (PMPM) Costs: State Plan Service Costs*	Incentive Costs*	1915(b)(3) Service Costs*	Administration Costs*	Total Actual Waiver Costs*	Prospective Year 1 (P1) Projection for State Plan: Base Year PMPM State Plan Service Costs* (Same as D13-D18)	State Plan Inflation Adjustment (Annual Year 1)	PMPM Effect of Inflation Adjustment (I*(1+J)^(2.5)-I)	Program Adjustment HPV, FQHC Maternity Expansion & Hospice	Program Adjustment Maternity Expansion, ABC Dental, Fee Increase	Program Adjustment Delayed Pmt of SFY07 Rate Pmt Increase
MEG 1	3,602,566	$ 234.03	$ -	$ -	$ 6.21	$ 240.24	$ 234.03	7.61%	$ 47.11	1.75%	6.95%	1.23%
MEG 2												
MEG 3												
MEG 4												
Total	3,602,566											
P1 PMPM Casemix for BY (BY MMs)		$ 234.03	$ -	$ -	$ 6.21	$ 240.24	$ 234.03	7.61%	$ 47.11	1.75%	6.95%	1.23%

* For comprehensive waivers, Columns D, E, F, G and H are columns K, L, M, N, and O from the Actual Waiver Cost Spreadsheet D3. For expedited waivers, sum the CMS-64.9 WAV and 64.21UWAV forms and divide by the member months for column D. Sum the CMS 64.10 WAV forms and divide by the member months for Column G. Sum D+G for Column H.

** If additional columns are needed in order to identify all of the adjustments being made, please insert the appropriate number of columns and label them accordingly.

*** The sum of the individual program changes may not equal the total due to rounding.

Medicaid Eligibility Group (MEG)	Base Year (BY) Member Months	P1 Per Member Per Month (PMPM) Costs: P1 PMPM State Plan Service Costs (same as S13-S18)	P1 PMPM Incentive Service Costs (same as W13-W18)	P1 PMPM 1915(b)(3) Service Costs (same as AA13-AA18)	P1 PMPM Administration Service Costs (same as AE13-AE18)	P1 PMPM Total Actual Waiver Costs (same as AF13-AF18)	Prospective Year 2 (P2) Projection for State Plan: P1 PMPM State Plan Service Cost Projection (Same as D30-D35)	State Plan Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (I+J)	Program Adjustment [Enter Description Here]	Program Adjustment [Enter Description Here]	Program Adjustment [Enter Description Here]
MEG 1	3,602,566	$ 317.02	$ -	$ -	$ 7.66	$ 324.68	$ 317.02	6.6%	$ 20.93	0.0%	0.0%	0.0%
MEG 2												
MEG 3												
MEG 4												
Total	3,602,566											
P2 PMPM Casemix for BY (BY MMs)		$ 317.02	$ -	$ -	$ 7.66	$ 324.68	$ 317.02	6.6%	$ 20.93	0.0%	0.0%	0.0%

Modify Line items as necessary to fit the MEGs of the program.
Show Connecticut Specific

Appendix D5. Waiver Cost Projection

Row # / Column Letter	B	O	P	Q	R	S
2						
3						
4						
5						
6						
7						
8		Services*				
9	Medicaid Eligibility Group (MEG)	Program Adjustment Dental Program Change	Program Adjustment Total***	PMPM Effect of Program Adjustment ((I+K)xP)	Aggregate PMPM Effect of State Plan Service Adj. (K+Q)	Total P1 PMPM State Plan Service Cost Projection (I+R)
10						
11						
12						
13	MEG 1	2.83%	12.76%	$ 35.87	$ 82.98	$ 317.02
14	MEG 2					
15	MEG 3					
16	MEG 4					
17	Total					
18	P1 PMPM Casemix for BY (BY MMs)	2.83%	12.76%	$ 35.87	$ 82.98	$ 317.02
19						
20						
21						
22						
23						
24						
25		Services*				
26	Medicaid Eligibility Group (MEG)	Program Adjustment [Enter Description Here]	Program Adjustment [Enter Description Here]	PMPM Effect of Program Adjustment ((I+K)xP)	Aggregate PMPM Effect of State Plan Service Adj. (K+Q)	Total P2 PMPM State Plan Service Cost Projection (I+R)
27						
28						
29						
30	MEG 1	0.0%	0.0%	$ -	$ 20.93	$ 337.95
31	MEG 2					
32	MEG 3					
33	MEG 4					
34	Total					
35	P2 PMPM Casemix for BY (BY MMs)	0.0%	0.0%	$ -	$ 20.93	$ 337.95
36	Modify Line items as necessary to fit the MEGs of the program.					
	Case Completion Sections					

Appendix D5. Walver Cost Projection

Actual Waiver Cost Initial Waiver Comprehensive Version
State of Connecticut
Note: Complete this Appendix for all Prospective Years
Waiver Cost Projection

Row # / Column Letter	B	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF
8		P1 Projection for Incentive Costs not Included in Capitation Rates**				P1 Projection for 1915(b)(3) Service Costs**				P1 Projection for Administration Costs**				
9–12	Medicaid Eligibility Group (MEG)	Base Year PMPM Incentive Costs* (Same as E13-E18)	Incentive Cost Inflation Adjustment (Annual Year 1)	PMPM Effect of Inflation Adjustment (Tx(1+U)^(2.5)-T)	Total P1 PMPM Incentive Cost Projection (T+V)	PMPM amount of Savings from State Plan	1915(b)(3) Service Costs Inflation Adjustment (Annual Year 1)	PMPM Effect of Inflation Adjustment (Xx(1+Y)^(2.5)-X)	Total P1 PMPM 1915(b)(3) Service Cost Projection (X+Z)	Base Year PMPM Administration Costs* (Same as G13-G18)	Administration Costs Inflation Adjustment (Annual Year 1)	PMPM Effect of Inflation Adjustment (ABx(1+AC)^(2.5)-AB)	Total P1 PMPM Administration Cost Projection (AB+AD)	Total P1 PMPM Projected Waiver Costs (S+W+AA+AE)
13	MEG 1	$ -		$ -	$ -	$ -		$ -	$ -	$ 6.21	8.79%	$ 1.45	$ 7.66	$ 324.68
14	MEG 2													
15	MEG 3													
16	MEG 4													
17	Total													
18	P1 PMPM Casemix for BY (BY MMs)	$ -	0.00%	$ -	$ -	$ -	0.00%	$ -	$ -	$ 6.21	8.79%	$ 1.45	$ 7.66	$ 324.68

Row # / Column Letter	B	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF
25		P2 Projection for Incentive Costs not Included in Capitation Rates**				P2 Projection for 1915(b)(3) Service Costs**				P2 Projection for Administration Costs**				
26–29	Medicaid Eligibility Group (MEG)	P1 PMPM Incentive Cost Projection (Same as E30-E35)	Incentive Cost Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (TxU)	Total P2 PMPM Incentive Cost Projection (T+V)	P1 PMPM 1915(b)(3) Service Cost Projection (Same as F30-F35)	1915(b)(3) Service Costs Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (XxY)	Total P2 PMPM 1915(b)(3) Service Cost Projection (X+Z)	P1 PMPM Administration Cost Projection (Same as G30-G35)	Administration Costs Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (ABxAC)	Total P2 PMPM Administration Cost Projection (AB+AD)	Total P2 PMPM Projected Waiver Costs (S+W+AA+AE)
30	MEG 1	$ -		$ -	$ -	$ -		$ -	$ -	$ 7.66	2.8%	$ 0.21	$ 7.87	$ 345.82
31	MEG 2													
32	MEG 3													
33	MEG 4													
34	Total													
35	P2 PMPM Casemix for BY (BY MMs)	$ -	0.0%	$ -	$ -	$ -	0.0%	$ -	$ -	$ 7.66	2.8%	$ 0.21	$ 7.87	$ 345.82

Modify Line Items as necessary to fit the MEGs of the program.
State Completion Section

Row # / Column Letter

B C D E F G H I J K L M N O

Quarterly CMS Targets for RO CMS-64 Review Initial Waiver
State of Connecticut

Projected Year 1

Row	Medicaid Eligibility Group (MEG)	Total Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs (Totals weighted on Projected Year 1 Member Months)					Total PMPM Projected Service Costs (Column H-G)
			Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
10	MEG 1	4,446,922	$ 317.02	$ -	$ -	$ 7.66	$ 324.68	$ 317.02
11	MEG 2							
12	MEG 3							
13	MEG 4							
14	Total	4,446,922						
15	P1 PMPM Casemix for P1 (P1 MMs)		$ 317.02	$ -	$ -	$ 7.66	$ 324.68	

Row	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs			Q2 Quarterly Projected Costs			Q3 Quarterly Projected Costs			Q4 Quarterly Projected Costs			Total P1 Projected Waiver Costs
		Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	
21	MEG 1	1,075,239	$ 340,867,916.83	$ 8,237,753.29	1,099,585	$ 348,585,987.23	$ 8,424,275.66	1,123,968	$ 356,315,787.23	$ 8,611,081.90	1,148,130	$ 363,975,526.70	$ 8,796,194.79	$ 1,443,814,523.82
22	MEG 2													
23	MEG 3													
24	MEG 4													
25	Total	1,075,239	$ 340,867,916.83	$ 8,237,753.29	1,099,585	$ 348,585,987.23	$ 8,424,275.66	1,123,968	$ 356,315,787.23	$ 8,611,081.90	1,148,130	$ 363,975,526.70	$ 8,796,194.79	$ 1,443,814,523.82

Projected Year 2

Row	Medicaid Eligibility Group (MEG)	Total Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs (Totals weighted on Projected Year 2 Member Months)					Total PMPM Projected Service Costs (Column H-G)
			Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
32	MEG 1	4,821,318	$ 337.95	$ -	$ -	$ 7.87	$ 345.82	$ 337.95
33	MEG 2							
34	MEG 3							
35	MEG 4							
36	Total	4,821,318						
37	P2 PMPM Casemix for P2 (P2 MMs)		$ 337.95	$ -	$ -	$ 7.87	$ 345.82	

Row	Medicaid Eligibility Group (MEG)	Q5 Quarterly Projected Costs			Q6 Quarterly Projected Costs			Q7 Quarterly Projected Costs			Q8 Quarterly Projected Costs			Total P2 Projected Waiver Costs
		Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	Member Months Projections	64.9WAIV/84.21UWAIV Service Costs Include Incentives	64.10 WAIV Administration Costs	
43	MEG 1	1,171,050	$ 395,753,829.25	$ 9,219,088.27	1,193,975	$ 403,501,283.70	$ 9,399,565.28	1,216,711	$ 411,184,866.00	$ 9,578,554.38	1,239,582	$ 418,914,071.27	$ 9,758,606.27	$ 1,667,309,864.42
44	MEG 2													
45	MEG 3													
46	MEG 4													
47	Total	1,171,050	$ 395,753,829.25	$ 9,219,088.27	1,193,975	$ 403,501,283.70	$ 9,399,565.28	1,216,711	$ 411,184,866.00	$ 9,578,554.38	1,239,582	$ 418,914,071.27	$ 9,758,606.27	$ 1,667,309,864.42

P Q R S T U

Quarterly CMS Targets for RO CMS-64 Review Renewal
State of Connecticut
Projection for Upcoming Waiver Period
Projections for RO CMS-64 Certification - Aggregate Cost

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs Start 7/1/2002	Q2 Quarterly Projected Costs Start 10/1/2002	Q3 Quarterly Projected Costs Start 1/1/2003	Q4 Quarterly Projected Costs Start 4/1/2003
64.21U Waiver Form	MEG 1	$ 340,667,916.83	$ 349,585,987.23	$ 356,315,787.23	$ 363,975,526.70
64.21U Waiver Form	MEG 2	$ -	$ -	$ -	$ -
64.9 Waiver Form	MEG 3	$ -	$ -	$ -	$ -
64.9 Waiver Form	MEG 4	$ -	$ -	$ -	$ -
64.19 Waiver Form		$ 8,237,753.29	$ 8,424,275.86	$ 8,611,061.90	$ 8,796,194.79

Waiver Form	Medicaid Eligibility Group (MEG)	Q5 Quarterly Projected Costs Start 7/1/2003	Q6 Quarterly Projected Costs Start 10/1/2003	Q7 Quarterly Projected Costs Start 1/1/2004	Q8 Quarterly Projected Costs Start 4/1/2004
64.21U Waiver Form	MEG 1	$ 395,753,829.25	$ 403,501,283.70	$ 411,184,866.00	$ 418,914,071.27
64.19 Waiver Form		$ 9,219,088.27	$ 9,399,565.28	$ 9,578,554.38	$ 9,758,606.27

State of Connecticut

Appendix D6. RO Targets

V W X Y Z AA AB AC AD AE AF AG AH AI

Quarterly CMS Targets for RO Cost-Effectiveness Monitoring
State of Connecticut
Projection for Upcoming Waiver Period
Worksheet for RO PMPM Cost-Effectiveness Monitoring

Projected Year 1 - xx/xx/xx - xx/xx/xx

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission P1 Projected PMPM From Column I (services) From Column G (Administration)
64.21U Waiver Form	MEG 1	$ 317.03
64.21U Waiver Form	MEG 2	$
64.9 Waiver Form	MEG 3	$
64.9 Waiver Form	MEG 4	$
64.16 Waiver Form	All MEGS	$ 7.64

Projected Year 1 - xx/xx/xx - xx/xx/xx

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring Q1 Quarterly Actual Costs			RO Completion Section - For ongoing monitoring Q2 Quarterly Actual Costs			RO Completion Section - For ongoing monitoring Q3 Quarterly Actual Costs			RO Completion Section - For ongoing monitoring Q4 Quarterly Actual Costs		
		Member Months Actuals Start 7/1/2003	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals Start 10/1/2003	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals Start 1/1/2004	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals Start 4/1/2004	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.21U Waiver Form	MEG 1			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.21U Waiver Form	MEG 2			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	MEG 3			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	MEG 4			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.16 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Projected Year 2 - xx/xx/xx - xx/xx/xx

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission P1 Projected PMPM From Column I (services) From Column G (Administration)
64.21U Waiver Form	MEG 1	$ 337.51
64.21U Waiver Form	MEG 2	
64.9 Waiver Form	MEG 3	
64.9 Waiver Form	MEG 4	
64.16 Waiver Form	All MEGS	$ 7.8

Projected Year 2 - xx/xx/xx - xx/xx/xx

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring Q5 Quarterly Actual Costs			RO Completion Section - For ongoing monitoring Q6 Quarterly Actual Costs			RO Completion Section - For ongoing monitoring Q7 Quarterly Actual Costs			RO Completion Section - For ongoing monitoring Q8 Quarterly Actual Costs		
		Member Months Actuals Start 7/1/2005	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals Start 10/1/2005	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals Start 1/1/2006	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals Start 4/1/2006	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.21U Waiver Form	MEG 1			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.21U Waiver Form	MEG 2			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	MEG 3			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	MEG 4			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.16 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Appendix D7. Summary

Cost Effectiveness Summary Sheet Initial Waiver
State of Connecticut

Costs to be input below are from the prior waiver submission. Compare the prospective years from the prior waiver submission to the retrospective years of the current waiver submission.

Row # / Column Letter	B	C	D	E	F	G	H	I	J	K	L	M	N
2													
3													
4													
5			Base Year Per Member Per Month (PMPM) Costs						CY2007* Per Member Per Month (PMPM) Costs from the prior waiver submission				
6	Medicaid Eligibility Group (MEG)	Base Year Member Months	BY PMPM State Plan Service Costs	BY PMPM Incentive Costs	BY PMPM 1915(b)(3) Service Costs (if applicable)	BY PMPM Administration Costs	BY PMPM Total Actual Waiver Costs		CY2007* PMPM State Plan Service Costs	CY2007* PMPM Incentive Costs	CY2007* PMPM 1915(b)(3) Service Costs	CY2007* PMPM Administration Costs	CY2007* PMPM Total Actual Waiver Costs
9	MEG 1	3,802,568	$ 234.53	$ -	$ -	$ 6.21	$ 240.24		$ 243.47	$ -	$ -	$ 10.52	$ 253.99
10	MEG 2												
11	MEG 3												
12	MEG 4												
13	Total	3,802,568											
14	BY Overall PMPM for BY (BY MMs)		$ 234.53	$ -	$ -	$ 6.21	$ 240.24		$ 243.47	$ -	$ -	$ 10.52	$ 253.99
15	Total Base Year Expenditures						$913,479,565		Total Previous CY2007* Projection using Base member months				$915,015,963
16									Total Difference between Projections of the Previous Waiver and Actual Waiver Cost for Base Year				$49,536,398

** Prior submission P1 and P2 were on a SPY basis. Because we are using CY2007 as our base period for this initial waiver we have used a weighting of the prior submission P1 and P2 to create a CY2007 projected PMPM. Specifically, we used a P1 PMPM of $235.91 for the State Plan Service Costs multiplied by the 3rd and 4th quarter MMs of P1: 1,899,643 and a P2 PMPM of $251.04 multiplied by the 1st and 2nd quarter MMs of P2: 1,895,678 to arrive at the CY2007 PMPM of $243.47. This same process was used to calculate a CY2007 administration PMPM using a P1 PMPM of $10.25 and a P2 PMPM of $10.78; using the same MM weighting, to arrive at a CY2007 admin PMPM of $10.52.*

17			P1 Projected PMPM Costs (Totals weighted on Projected Year 1 Member Months)						
18	Medicaid Eligibility Group (MEG)	Projected Year 1 Member Months (P1)	P1 PMPM State Plan Service Cost Projection	P1 PMPM Incentive Cost Projection	P1 PMPM 1915(b)(3) Service Cost Projection	P1 PMPM Administration Cost Projection	P1 PMPM Projected Waiver Costs	Overall BY to P1 Change (annual)	
21	MEG 1	4,446,922	$ 317.02	$ -	$ -	$ 7.66	$ 324.68	12.8%	
22	MEG 2								
23	MEG 3								
24	MEG 4								
25	Total	4,446,922							
26	P1 Weighted Average PMPM Casemix for BY (BY MMs)		$ 317.02	$ -	$ -	$ 7.66	$ 324.68	12.8%	
27	P1 Weighted Average PMPM Casemix for P1 (P1 MMs)		$ 317.02	$ -	$ -	$ 7.66	$ 324.68	12.8%	
28	Total Projected Waiver Expenditures P1 including casemix						$1,443,814,924		

30			P2 Projected PMPM Costs (Totals weighted on Projected Year 2 Member Months)						
31	Medicaid Eligibility Group (MEG)	Projected Year 2 Member Months (P2)	P2 PMPM State Plan Service Cost Projection	P2 PMPM Incentive Cost Projection	P2 PMPM 1915(b)(3) Service Cost Projection	P2 PMPM Administration Cost Projection	P2 PMPM Projected Waiver Costs	Overall P1 to P2 Change (annual)	
34	MEG 1	4,821,318	$ 337.95	$ -	$ -	$ 7.87	$ 345.82	6.5%	
35	MEG 2								
36	MEG 3								
37	MEG 4								
38	Total	4,821,318							
39	P2 Weighted Average PMPM Casemix for P1 (P1 MMs)		$ 337.95	$ -	$ -	$ 7.87	$ 345.82	6.5%	
40	P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		$ 337.95	$ -	$ -	$ 7.87	$ 345.82	6.5%	
41	Total Projected Waiver Expenditures P2 including casemix						$1,667,309,664		

43					
44	Medicaid Eligibility Group (MEG)	Projected Year 1 and 2 Member Months (P1+P2)	Overall BY to P2 Change (monthly)	Overall BY to P2 Change (annualized)	
47	MEG 1	9,268,240	8.9%	11.0%	
48	MEG 2	-			
49	MEG 3	-			
50	MEG 4	-			
51	Total	9,268,240			
52	P2 Weighted Average PMPM Casemix for BY (BY MMs)		8.9%	11.0%	
53	P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		8.9%	11.0%	
54	Total Projected Waiver Expenditures P2 + P1 including casemix			$3,111,124,588	

Modify Line items as necessary to fit the MEGs of the program.

Data Completion Instructions:

To modify the formulas as necessary to fit the length of this program complete this section. The formulas will automatically update given the data.

NUMBER OF MONTHS OF DATA	
BY	12
Gap (end of BY to P1)	18
P1	12
P2	12
TOTAL	54
(Months-12)	42

Connecticut Health Policy Project

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Phone (203) 562-1636 • Fax (203) 562-1637 • www.cthealthpolicy.org

February 25, 2009

David Parrella
Medical Care Administration – 11th floor
Department of Social Services
25 Sigourney Street
Hartford CT 06106-5033

Dear Mr. Parrella:

I am writing to comment on the Department's draft HUSKY waiver proposal. Specifically, my comments relate to the Department's plans for Primary Care Case Management (PCCM).

The CT Health Policy Project's strongly supports the Department's PCCM program. We believe that a strong PCCM program is critical to the long term health of HUSKY. Development of PCCM in Connecticut, as we envisioned in the Department's working group, will be provider and consumer driven. We expect PCCM to attract more providers to HUSKY and result in significant improvements in access and quality of care for consumers. PCCM offers an important alternative to the HUSKY HMOs for consumers, providers and policymakers. Competition between the two programs should encourage better performance and accountability in both options. Care coordination, the centerpiece of PCCM, will ensure the most efficient use of scarce resources in the program.

I am pleased to see and agree with the proposal's contention that PCCM will not impact the cost-effectiveness of the program; that savings generated by PCCM will offset the PCCM management fees, any additional administrative costs, and any possible utilization increases (p. 88 of the waiver proposal document). We at the CT Health Policy Project believe it could result in significant savings over our current system.

I am concerned however that the proposal only describes PCCM as a severely limited program only available to the small number of HUSKY families who are current patients of PCCM providers only in the Waterbury or Willimantic areas (pp. 7, 10, 11, 18 and 19). This was not the agreement of the working group nor does it reflect the Department's plan for PCCM submitted and approved, without revision, by the Appropriations and Human Services Committees last fall. That plan states "The geographic areas for the pilot will be defined based on the catchment area of providers who choose to enroll in the PCCM pilot." Providers from across the state have applied to participate in PCCM, far more than just those serving Waterbury and Willimantic. In fact, there has been a great deal of interest in PCCM from providers. As you know, HUSKY has struggled to attract participating providers since the program's inception. I am concerned that the policy

changes you have proposed are endangering progress in expanding provider panels, and consequently access to care for HUSKY families. I am also concerned that such severe limitations on eligibility will endanger the entire program by artificially suppressing enrollment in PCCM. At the CT Health Policy Project, we have received many calls from consumers eager to enroll in PCCM. However enrollment levels to date have not reflected the consumer interest due to the limitations the Department has imposed, not because there is not interest in the program.

I urge you to revise the HUSKY waiver proposal to give every HUSKY family and provider in Connecticut the option of participating in PCCM.

Thank you for your time and your commitment to the health of all HUSKY members.

Sincerely,

Ellen M Andrews

Ellen Andrews, PhD
Executive Director

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

February 27, 2009

Ellen Andrews, PHD
Executive Director
Connecticut Health Policy Project
703 Whitney Avenue
New Haven, CT 06511

Dear Dr. Andrews:

Thank you for your comments to the Department's draft 1915(b) waiver application dated February 25, 2009.

The Department agrees that Primary Care Case Management (PCCM) is an important part of our managed care program, and we appreciate the enthusiasm of various stakeholders about PCCM.

Consistent with the authorizing legislation and the Department's legislative plan, PCCM is initially being implemented as a pilot program. There are many challenges in launching and operating this new program, and we therefore believe that building off of a successful pilot program is in the best interests of PCCM. As the Department has expressed numerous times, including in the waiver application (pages 11 and 18), we plan to expand PCCM to additional areas based on the successes of the PCCM pilot program.

Additionally, while providers across the state have expressed interest in PCCM, we need participation in an area from providers for both adults and children in order to make PCCM available. Currently, there are few areas in the state in which significant numbers of providers for adults have applied for PCCM. Although the pilot is currently available only to the HUSKY families who are current patients of PCCM providers in the Waterbury or Willimantic areas, the Department does not agree that this policy is endangering progress in expanding provider panels. To the contrary, the Department believes that a thoughtful, planned expansion based on a better developed program model from lessons learned during the pilot will be more attractive to providers currently participating in HUSKY as well as attracting new providers.

As specifics about the best way to expand PCCM become more clear, the Department will move forward with our plan to expand PCCM beyond the initial pilot sites. However, it is premature at this point to include precise details about PCCM expansion in the current waiver application.

Sincerely,

David Parrella
Director, Medical Care Administration

cc: Fran Freer, Acting Deputy Commissioner